

# **AGREEMENT BETWEEN THE HEALTH CARE FINANCING ADMINISTRATION AND THE STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES**

**Scope and Purpose of Agreement.** This document represents the agreement between the Health Care Financing Administration (HCFA) and the State of California, Department of Health Services (State) for:

- (1) Resolving retroactive claims under the Medi-Cal Administrative Claiming System (MAC) for the period July 1, 1992 through December 31, 1994 (the resolution period),
- (2) Claiming targeted case management (TCM) services and Medi-Cal administrative costs for the period January 1, 1995 through June 30, 1995 (the transition period), and
- (3) Claiming the costs of Medi-Cal administrative activities (MAA) under the Administrative Claiming Process (ACP) beginning on or after July 1, 1995.

The parties to this agreement are the State of California, Department of Health Services, and the Health Care Financing Administration. The purpose of this agreement is to prescribe the processes for identifying, documenting, and paying allowable Medi-Cal administrative activities, as defined in existing HCFA guidance and as set forth in this agreement, for the resolution period, the transition period, and the ongoing ACP as described in Sections I, II and III of this agreement, respectively. Section IV provides the HCFA and State agreement on TCM rate contents for periods beginning July 1, 1995.

For purposes of claiming costs under this agreement for the resolution period or the transition period, a Local Governmental Agency (LGA) must submit a claim to the State for payment by close of business on **January 31, 1996**. No claims will be reviewed or approved under this Agreement which are initially submitted after January 31, 1996. This deadline does not apply to the correction of claims.

**Overall Guiding Principles.** HCFA and the State agree to the following overall guiding principles for identifying, documenting, and paying allowable Medi-Cal administrative costs and TCM services:

- (1) **No Duplicate Payments**--In determining allowable administrative costs, the basic principle is that duplicate payments are **not** allowable (See OMB Circular A-87). That is, payments for allowable Medi-Cal administrative activities must not duplicate payments that HCFA believes have been (or should have been) included and paid as part of outpatient clinic rates, targeted case management (TCM) services, part of a capitation rate, or through some other State or Federal program. In no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including State, local, and Federal funds. It is the State's responsibility to ensure that there is no duplication in the claims prior to the State submitting any claims for HCFA review. The State reserves the right to dispute

HCFA's position on what is a duplicate payment through appeal of any disallowance to the Departmental Appeals Board.

(2) Not A Precedent--The State and HCFA intend to develop mutually agreeable mechanisms which are solely for the purpose of expediting payment of clearly allowable Medi-Cal administrative costs embedded in the retroactive MAC claims for the resolution period and the transition period as well as for claiming targeted case management (TCM) services during the transition period. The State and HCFA do not intend this to be a precedent setting claiming mechanism for any other claims or issues, past, present, or future, Medi-Cal or otherwise. However, an adapted version of these administrative claiming mechanisms will be used for the ongoing ACP as described in Section III.

Once the mechanisms for the resolution period and the transition period are developed, implemented, and claims made, and paid by HCFA as allowable, no further claims can be submitted by the State/local jurisdiction as part of the resolution or transition periods, nor can HCFA review or otherwise reconsider such resolution or transition period claims at a later date. However, in accordance with instructions provided by the State, the local jurisdictions may separately continue to develop and submit MAC claims to the State for the resolution period July 1, 1992 through December 31, 1994, based upon the MAC system as designed, in order to preserve their appeal rights. Only claims within the universe of claims as defined in the April 28, 1995 letter (see **Attachment 1**) issued to all MAC Coordinators on guidelines for submitting resolution period claims and the September 8, 1995 letter (see **Attachment 2**) to all MAC Coordinators for submitting transition period claims will be processed under this Agreement. Claims outside the agreed upon universe of claims will not be reviewed or approved.

(3) State Responsibility--It is the State's responsibility to present the revised resolution period and transition period Local Governmental Agency's (LGA) claims in readily reviewable form to HCFA for review, and after HCFA's approval, to submit those approved claims on the appropriate Form HCFA-64.

(4) HCFA Responsibility--It is HCFA's responsibility to provide the State with any technical assistance required during the resolution, transition, and ACP processes, to provide the State with definitive written guidance and all necessary approvals at each step in these processes, and to review and approve allowable claims and expedite (for the resolution and transition periods only) the payment to the State of those allowable claims.

The terms LGA and local jurisdiction are used interchangeably throughout the Agreement.

The following sections I-IV, respectively, detail the HCFA/State agreement for resolving claims for the resolution period, claiming TCM services in the transition period, claiming the costs of Medi-Cal administrative activities under the ACP beginning July 1, 1995, and TCM rate contents beginning July 1, 1995.

**I. RESOLUTION PERIOD**

The process of identifying allowable Medi-Cal administrative costs embedded in the MAC claims for the resolution period, as defined in existing HCFA guidance and as set forth in this agreement, does not constitute an admission by the State that the MAC system as designed and implemented was incorrect or flawed. Likewise, HCFA's participation in this process does not constitute an admission by HCFA that the issues identified in the March 1 and May 9, 1995 disallowance letters (**see Attachments 3 and 4**) and the October 7, 1994, February 17, 1995, and August 30, 1995 deferral letters were incorrect or that the MAC system is approvable.

The resolution process described in this section of this agreement is to be used solely to expedite payment of those costs embedded in the MAC claims which are clearly reimbursable as allowable Medi-Cal administrative costs under existing law, regulations, and HCFA guidance for the resolution period July 1, 1992 through December 31, 1994. Disputes on allowability of activities or costs will not be resolved through this resolution process. The State reserves the right to dispute HCFA's position on such matters through appeal of any disallowance to the Departmental Appeals Board and HCFA reserves the right to defend its position in such appeal.

**Steps to Identify and Resolve Allowable Medi-Cal Administrative Activities.**

HCFA and the State agree on the following 4 step process to identify and resolve those allowable Medi-Cal administrative activities which are embedded in the MAC claims for the resolution period:

1. Define the allowable Medi-Cal administrative activities, as set forth in this agreement, in accordance with existing applicable HCFA guidance.
2. Document the allowable Medi-Cal administrative activities that are being performed and the percentage of time being spent on those activities for each program or claiming unit within the program in each local jurisdiction in the claim universe for the resolution period, as set forth in this agreement.
3. Establish the allowable Medi-Cal percentage for each program or claiming unit within the program, as set forth in this agreement.
4. Determine the allowable Medi-Cal administrative costs for the allowable Medi-Cal administrative activities, as set forth in this agreement.

The implementation of these four steps is described in detail below. Following extensive HCFA/State negotiation and agreement, steps 1 through 3 have been accomplished, except with respect to the Alcohol and Drug Programs administered by the LGAs.

**STEP 1. DEFINE THE ALLOWABLE MEDI-CAL ADMINISTRATIVE ACTIVITIES, AS SET FORTH IN THIS AGREEMENT, IN ACCORDANCE WITH EXISTING APPLICABLE HCFA GUIDANCE.**

**A. Construct Master Activity Lists**--A survey form listing all the activities performed by employees who participated in the MAC time studies for each program was constructed, with the exception of the Alcohol and Drug Programs. Each of the programs now claiming under the MAC process (i.e. school personnel, public health nursing, public guardian, mental health, adult probation, hospital/health department outpatient clinics, linkages/aging, and county veterans services officers) developed a comprehensive, all-inclusive list of activities performed by the staff who were time studied for that program. The listing of activities was specific enough so that allowable Medi-Cal administrative activities, in accordance with existing HCFA guidance, could be distinguished from unallowable activities. These activities were more specific and descriptive than the activity codes in the MAC Cookbook/MAC Manual and those MAC codes were not used as the basis for the new activity lists.

There is one master activity list for each program statewide. Claiming units within larger programs (e.g., maternal and child health or field nursing services within public health) were allowed to use the survey developed for that program in order to submit a separate claim, so long as the percentages of allowable time were reported separately for that claiming unit, and the costs of that claiming unit were separated from the costs of the larger program in submitting the claim. Each activity in each program was assigned a unique identifier code by the State to facilitate accumulation and summarization of the data. The lists were initially developed by the local jurisdictions, submitted to the State for review, and then submitted to HCFA. The State and HCFA then jointly agreed to and approved the final listing of activities for each program that were used in the resolution process.

**B. Determine Allowable Activities**--Once these master lists of activities by program were completed and distributed to the local jurisdictions, HCFA and the State worked together to establish which of the activities in each program were allowable Medi-Cal administrative activities, in accordance with existing HCFA guidance. **Attachment 5, Allowability of Cost Categories--Resolution Period**, contains the operating principles and guidelines used to determine the allowability of activities during the resolution period. HCFA and the State also established which activities met the skilled professional medical personnel (SPMP) criteria and were allowable at 75 percent FFP when performed by skilled professional medical personnel in accordance with the requirements at 42 CFR 432.50. HCFA and the State also agreed the directly supporting staff may be claimed in the same allowable proportion as the skilled professional medical personnel that they directly support for this resolution process only. Also, if an SPMP designated activity is being performed by non-SPMP, the activity was allowed at 50 percent FFP.

The master lists of allowable activities produced by this process were not provided to any of the programs or claiming units involved in using the program activity lists to implement the specific options described below until HCFA approved of their

distribution. Additionally, the employees of the programs or claiming units participating in the resolution process did not receive any other instruction or coaching regarding the percentages of time the employee reported for any activity in the actual completion of the documents involved in the resolution process other than that provided with the approved resolution process documents themselves. Employees were also not given any other instructions on how to fill out percentages of time, other than with respect to the paid time off category as described below.

**C. Dispute Resolution on Allowable Activities**--Where any disputes arose regarding the determination of which activities were allowable Medi-Cal administrative activities, or the rate of FFP (75%/50%) for these activities, and where the State and HCFA did not reach agreement, the HCFA determination was used for the resolution process and the State reserved its right to appeal these disputes.

**STEP 2. DOCUMENT THE ALLOWABLE MEDI-CAL ADMINISTRATIVE ACTIVITIES THAT ARE BEING PERFORMED AND THE PERCENTAGE OF TIME BEING SPENT ON THOSE ACTIVITIES FOR EACH PROGRAM OR CLAIMING UNIT WITHIN THE PROGRAM IN EACH LOCAL JURISDICTION IN THE CLAIM UNIVERSE FOR THE RESOLUTION PERIOD, AS SET FORTH IN THIS AGREEMENT.**

**3 Options to Document Allowable Medi-Cal Administrative Activities.** There were three options approved by the State and HCFA to complete this task. A program or claiming unit selected the option it wanted to use and then used that option to document its claim. A local jurisdiction was allowed to use one option for one program and another option for a second program depending upon the circumstances of each program in the local jurisdiction. However, once an option was chosen, then that option had to be consistently applied for that program or claiming unit for all time periods claimed.

The three options were:

**OPTION 1. Time Survey and Certification**--The local program or claiming unit had to make every effort to ensure that each employee who participated in the MAC time study program, and who was still employed by that program, for which the local jurisdiction was now allowed to submit a claim as part of this resolution process, completed a survey form for that program. The employee estimated the percentage of time spent on each activity for the period January 1, 1994 to December 31, 1994 for the applicable program. Where an employee did not spend any time on an activity in the list the employee must have affirmatively indicated this by placing a zero next to that activity. The total percentage for the employee for the program had to total 100 percent. Employees in a position for 6 months or more during the survey year completed a survey. Employees in a position for less than 6 months during the survey year did not need to complete a survey.

**Treatment of Unpaid Time Off (UPTO) and Paid Time OFF (PTO) in Activities Surveys.** Employees sometimes have periods for which they are not paid. For example,

although school-based employees may have a yearly contract and are paid with respect to the entire year, they typically do not actually work every month of the year (i.e., they are off during the summer months). During the school year they may also get paid leave such as for illness, bereavement, and for personal days. School-based employees can also choose to work during the summer months for extra pay. Finally, in certain local jurisdictions, the school year runs year-round. In such areas, the periods of time off could be staggered throughout the years for different employees. Under this agreement, for purposes of claiming administrative costs in the resolution period, UPTO was NOT included on the survey and PTO was included.

PTO was treated under one of two methods described below (for each program/by local jurisdiction):

Method 1.—Under Method 1, each employee responding to the survey completed the PTO activity on the survey in the same way as they would for any other survey activity (by indicating their estimate of the percentage of time spent in PTO). The local jurisdiction then determined the average percentage for each activity of the program or claiming unit.

Method 2.—Under Method 2, if the program or claiming unit was able to document actual PTO for each employee, it used the actual amounts of PTO, rather than relying on the employees' estimates of their PTO. Under this method, the program or claiming unit instructed the employees completing the survey not to complete the PTO activity. In these programs or claiming units, the employees completed all remaining activities as if they were the only activities on the survey. That is, the total of the percentages of time for the remaining activities is 100%. The programs or claiming units then compiled the average percentages for each of these remaining activities.

Then, relying on records of actual PTO for employees of the program or claiming unit, the program or claiming unit determined the average percent time for PTO for each employee. The program or claiming unit then reduced the average percentages of the activities, other than PTO, by the prorated amount of the average PTO percentage. This ensured that all activities bore their share of PTO.

The following example, using 5 activities (A, B, C, D and PTO), illustrates how Option 2 is applied.

Activities Percentages With PTO Omitted, and the PTO Prorated to the Other Activities (the Average PTO/Employee = 5%):

<u>Activity</u>	<u>Average % Time</u>	<u>Prorated % PTO</u>
A	10%	.1 x 5% = 0.5%
B	20%	.2 x 5% = 1.0%
C	30%	.3 x 5% = 1.5%
D	40%	.4 x 5% = 2.0%
Total	100%	5.0%

Revised Average Percent Time for All Activities (With PTO Included):

<u>Activity</u>	<u>Average % Time</u>
A	10% - 0.5% = 9.5%
B	20% - 1.0% = 19%
C	30% - 1.5% = 28.5%
D	40% - 2.0% = 38%
PTO	5.0%
Total	100%

Survey language other than that contained in the final survey forms was NOT used and the order of the activity codes was not changed in any way.

Employees were allowed to refer to any existing contemporaneous records or other documentation for the period January 1, 1994 through December 31, 1994 that was available to them to refresh their recollections of their activities and the amount of time they spent on those activities. The employees were not to rely on the MAC time studies.

Upon completion of the survey the employee signed and dated the employee certification statement. The employees gave the completed surveys to their immediate supervisors.

The immediate supervisor, with first hand knowledge of the activities performed by the employee during the applicable 12-month period, reviewed the survey and signed and dated the supervisor certification statement. If the immediate supervisor could not or would not verify the results of the time study or survey, then that survey or log was not used in calculating the program or claiming unit's allowable percentage. If this occurred the local jurisdiction was to submit a written explanation for each instance, fully explaining why the supervisor could not or would not verify the results. HCFA reserved the right to review and make a final determination on any such cases.

**OPTION 2. 2-Week Time Study**—Alternatively, with respect to a MAC program, for which the program or claiming unit was allowed to submit a claim as part of this resolution process, the program or claiming unit could have chosen to complete a 2-week time study of employees in that program who participated in the MAC time studies. This 2-week time study used the same Statewide list of approved activities for the program being time studied as developed for the surveys in Option 1 above. The time study log required staff to record or identify the following elements: the client for whom the activity was performed, the client's Medi-Cal status/number, time spent by the employees, activity code from approved listing, brief description of activity performed, and the location where the activity was performed. If this option was selected, all the employees in the program or claiming unit being time studied had to time study for the same 2-week period.

Upon completion of the time study each employee signed and dated the employee certification statement. The employees gave the completed time studies to their immediate supervisors.

The immediate supervisor with first hand knowledge of the activities performed by the employee during the applicable 2-week time study period reviewed the time study and signed and dated the supervisor certification statement. If the immediate supervisor could not or would not verify the results of the time study or survey, then that survey or log was not used in calculating the program or claiming unit's allowable percentage. If this occurred, the local jurisdiction was to submit a written explanation for each instance, fully explaining why the supervisor could not or would not verify the results. HCFA reserved the right to review and make a final determination on any such cases.

**OPTION 3. Contemporaneous Records Reconstruction**— Alternatively, with respect to a MAC program for which the program or claiming unit was allowed to submit a claim as part of this resolution process, the program or claiming unit could have chosen to analyze a representative sample of contemporaneous records to extract the percentage of time that was spent on each of the activities in the approved activities listing for that program. The approved activities for that program were the same activities developed for the surveys under Option 1 above. This option was only available for those programs which had contemporaneous records such as nursing logs, activity logs, case records, other non-MAC time sheets/studies/logs, etc.. The employees and their supervisors in the program analyzed these records to determine the activities of the employee during the sample period and indicated that percentage for the applicable activity on the approved activity listing for that program using the survey form.

Each local jurisdiction using this option had to submit documentation to support how its percentages were derived for each activity, describe the documentation utilized, and describe the sample period used to construct the percentages.

Upon completion of the reconstructed record the employee signed and dated the employee certification statement. The employees then gave the completed survey to their immediate supervisors.

The immediate supervisor, with first hand knowledge of the activities performed by the employee during the applicable sample period, reviewed the survey and signed and dated the supervisor certification statement. If the immediate supervisor could not or would not verify the results of the record reconstruction, then that reconstruction survey was not used in calculating the program or claiming unit's allowable percentage. Whenever this occurred the local jurisdiction had to submit a written explanation for each instance which fully explains why the supervisor could not or would not verify the results. HCFA reserved the right to review and make a final determination on any such cases.

**Compile and Submit Results to the State.** After the surveys, time studies, or contemporaneous records reconstruction were completed under Options 1, 2, or 3, respectively, the local jurisdictions prepared a summary of the results for each program



or claiming unit using the Retroactive Resolution Process Summary Reporting Form. They also compiled a summary activity list for each program or claiming unit for the SPMP and NonSPMP employees using the Summary Report Form. This required compiling a Summary Report Form for each program or claiming unit which totals all of that program or claiming unit's results for each of the activities in that program or claiming unit for both the SPMP and NonSPMP employees.

After completing the Retroactive Resolution Process Summary Reporting Form and Summary Report Form for each program or claiming unit, the person designated by the LGA to oversee the resolution process in that local jurisdiction signed and dated the LGA certification statement included on the Summary Report Form for each program or claiming unit. The Summary Report Form and the Retroactive Resolution Process Summary Reporting Form for each program and claiming unit were then submitted to the State according to the instructions agreed to by HCFA and the State and provided to the MAC coordinators on April 12, 1995. At the time the LGA submitted this information it also submitted to the State the Medi-Cal percentage(s) it was proposing to use for each claim (see further discussion below).

The LGA also submitted to the State ten sample copies of the surveys, time study logs, etc., completed by employees for each claiming unit for which a claim was submitted. However, if the claiming unit had less than 10 employees, the local lead agency submitted all the copies of the surveys, time study logs, etc. completed by the employees for that claiming unit for which a claim was submitted. This information was submitted to the State with the summary information above. The local jurisdictions were not required to submit all of the supporting survey forms, time studies, or contemporaneous records with the summary sheets. Instead these must be maintained, in readily reviewable form, in an audit file at the local jurisdiction by program and be made available to the State and HCFA upon request in accordance with the record retention requirements at 42 CFR 433.32.

The State entered the summary activity averages for each County by claiming unit, using a Lotus spreadsheet developed by the State and HCFA for the purposes of compiling and arraying the data. The spreadsheet also indicated which activities were allowable and which activities were, or were not, discounted by the Medi-Cal percentage according to the master list of allowable activities. The completed spreadsheets for each program were then provided to HCFA by the State to review and analyze.

**HCFA Testing of the Results.** HCFA used the following process to validate the information provided by the State:

- (1) For each allowable activity within each program, HCFA established an outlier percentage cutoff. This cutoff percentage was set so that it identified any reported claiming unit percentage that was in the upper 10 percent of the reported percentages for an activity. The outlier percentage cutoff for each activity was calculated by adding 1.282 standard deviations to the Statewide average for the percentages reported for the activity. If the activity percentage

reported exceeded that computed percentage cutoff amount, the reported percentage was designated by HCFA as an outlier percentage. If the activity percentage reported was equal to or less than that computed cutoff percentage, the reported percentage was designated by HCFA as allowable.

(2) For each designated outlier percentage, HCFA then reviewed the 10 sample activity surveys provided by each local jurisdiction with their survey results and the documentation provided by each local jurisdiction in response to the March 3, 1995 MAC documentation survey. If this documentation supported the outlier percentage, HCFA designated the percentage as allowable. If this documentation did not support the outlier percentage, this percentage was identified as an outlier by HCFA requiring further action by the State.

(3) For the outlier percentages identified in Step 2 above, the State and local jurisdiction were given the opportunity to adequately document the outlier percentage to HCFA. The State sent a letter to each local jurisdiction having an outlier percentage which requested that additional justification and/or supporting documentation be submitted to support the outlier percentage. Based upon HCFA's review of the additional justification and/or documentation presented, HCFA made a final decision on each outlier percentage as follows. (A) In each case where additional justification and/or documentation was provided, HCFA allowed the outlier percentage as reported, or (B) in each case where no additional justification and/or documentation was provided, HCFA allowed the adjusted statewide percentage for that activity in lieu of the outlier percentage that was reported. The adjusted statewide percentage for an activity was the statewide average for that activity computed without including any of the unallowable outlier percentages in the calculation.

Once HCFA has approved the allowable percentages for a program or claiming unit for a local jurisdiction, those percentages must be used to resolve all of the claims for that program or claiming unit in that local jurisdiction under this resolution process. HCFA, the State, and the local jurisdictions are bound by the approved percentages established through this process and they will not be subject to further audit, review, modification or appeal.

**STEP 3. ESTABLISH THE ALLOWABLE MEDI-CAL PERCENTAGE FOR EACH PROGRAM OR CLAIMING UNIT WITHIN THE PROGRAM, AS SET FORTH IN THIS AGREEMENT**

HCFA reviewed and approved the Medi-Cal percentages submitted by the programs or claiming units. Except for the methods approved for school districts discussed below, the only HCFA-approved methods for the resolution process for deriving the Medi-Cal percentages were:

- (1) the county-wide Medi-Cal average (for SFY 1992/93 the SFY 1992/93 Table and for SFYs 1993/94 and 1994/95 the SFY 1993/94 Table) as determined by the Medical Care Statistics Section, DHS,
- (2) actual 100% client counts from the applicable MAC time study periods, and
- (3) any other method submitted to and approved by HCFA.

Actual client counts were used for any program or claiming unit for which they were available. If the local jurisdiction used actual client counts they had to be client counts for that program or claiming unit. Client counts unrelated to the program or claiming unit being claimed were not used. Once a method was chosen by a program or claiming unit and approved by HCFA, it was used consistently for that program or claiming unit in order to provide the most accurate representation of the amount of Medi-Cal activity for that program. A program or claiming unit could not pick and choose among methods.

Methods To Be Used by School Districts for Establishing the Medi-Cal Percentage

Unified school district claiming units could avail themselves of three additional options which were approved by HCFA in addition to the county-wide average and actual client counts, as follows:

1) Unadjusted AFDC Count: Unified school districts could have utilized the annual listing of AFDC students by the schools in the district to calculate a district-wide percentage of AFDC eligibles in the schools in that district. This district-wide AFDC percentage served as the Medi-Cal percentage for the resolution process.

2) DHS Tape Match: Local education agencies ("LEA's") which participate in the LEA Medi-Cal billing option had access to tape matches of school enrollments with Medi-Cal computer eligibility files. These tape matches identify the numbers of students enrolled in a school who are Medi-Cal eligible. Subject to HCFA review and approval, these tape matches were used as the basis to calculate a unified district-wide Medi-Cal percentage for the resolution process.

3) Adjusted AFDC Count: For those LEA's which do not participate in the LEA billing option, the district-wide percentage of AFDC enrollees was increased by a factor provided by the State and approved by HCFA, to account for non-AFDC Medi-Cal eligible students in the district, such as SSI disabled children, foster children, and those in certain optional eligibility groups. This adjusted AFDC percentage served as the Medi-Cal percentage for the resolution process.

**The free and reduced lunch discount method for calculating the Medi-Cal percentage for school districts was not approved for use during the resolution process.**

**STEP 4. DETERMINE THE ALLOWABLE MEDI-CAL ADMINISTRATIVE COSTS FOR THE ALLOWABLE MEDI-CAL ADMINISTRATIVE ACTIVITIES, AS SET FORTH IN THIS AGREEMENT**

Recomputation of Claims. Once HCFA approved the allowable percentages of time and the Medi-Cal percentages for each program and claiming unit, the information was sent to the appropriate jurisdiction by letter from the State. Using the 1994/95 MAC Invoice, as modified by the State for this resolution process and approved by HCFA, each program or claiming unit was required to recompute its claims using the approved activity and Medi-Cal percentages, the applicable allowable costs, and the appropriate Federal matching rate (75/50%). The approved program or applicable claiming unit percentages were used for all of the periods for which claims were submitted.

Submission of Invoices by Programs/Claiming Units. Every program or claiming unit (including contractors) submitted a detailed invoice to the lead agency of the LGA to review and submit to the State. Each of the detailed invoices were required to be supported by the following: (1) a complete listing of all revenue sources for the program or claiming unit, (2) identification of all of the revenues from that list that were offset against reported costs, (3) a listing of all costs included in the "other costs" of each cost pool, (4) what staff are included in cost pool number 4, and (5) the time weighted average of the approved Medi-Cal percentages applicable to the claiming periods where more than one Medi-Cal percentage is applicable.

MAC claims for each program or claiming unit were normally submitted for each quarter. However, for this resolution period claims are to be submitted as follows:

(1) Annual claims for State fiscal year 1992/1993 were only to be submitted if claims for the first three quarters of 1992/1993 had previously been submitted to the State and claimed on the Form HCFA-64 by the State and the fourth quarter had been time studied using the MAC time study system as specified in the MAC Cookbook/MAC Manual. These quarters may be aggregated into one claim per program or claiming unit. Otherwise, a claim could be submitted only for the fourth quarter of 1992/1993, if that quarter was time studied.

(2) Annual claims for State fiscal year 1993/1994 may be prepared and submitted as specified in the universe of claims guidelines contained in the "Instructions for the Detailed Invoice and Program Summary Invoice Under the Retroactive Resolution Process" dated April 28, 1995.

(3) Claims for the first two quarters of State fiscal year 1994/1995 may be aggregated into one claim for the programs or claiming units specified in the "Instructions for the Detailed Invoice and Program Summary Invoice Under the Retroactive Resolution Process" dated April 28, 1995.

**Submission of Invoices to State.** When the invoices are completed and signed, they are to be submitted to the State in accordance with the April 28, 1995, "Instructions for the Detailed Invoice and Program Summary Invoice Under the Retroactive Resolution Process." In accordance with 42 CFR 430.30, 42 CFR 431.17, 42 CFR 433.32, and 45 CFR 74.51-74.53, the State is to review all of the detailed invoices and ensure that the correct allowable activity percentages for each program have been applied, that the correct allowable Medi-Cal percentages have been applied, that the applicable revenue offsets have been properly applied to the cost pools, and that the cost pools are properly constructed.

The State indicates that its review and approval is complete by signing the "Retroactive MAC Invoice Review Checklist" and then making available all of the State approved invoices, and any necessary supporting documentation, to HCFA for review. On an ongoing basis, the State notifies HCFA that the State approved invoices are available for review and places those invoices in the designated HCFA review file at the Federal Liaison Unit office.

**HCFA Review of Claims.** Upon notification, HCFA staff (including staff from the Department of Health and Human Services, Office of Inspector General) reviews the claims presented on an ongoing basis to ensure that: the costs are allowable, the revenue offsets are applied, the correct activity and Medi-Cal percentages are used, and the claim form formulas were not altered, and that the claims were correctly computed. HCFA and OIG staff indicate approval of claims by signing the "Retroactive MAC Invoice Review Checklist" and the "Medi-Cal Administrative Claiming Retroactive Resolution Process" approval letter. The State then pays the allowable claims through the State's normal Medi-Cal claims payment process after offsetting any amounts previously paid the claiming unit under the MAC process.

Whenever problems with specific claims are identified by the State and/or HCFA, those claims are to be returned to the local jurisdiction with a Notice of Invoice Dispute form which explains the problem(s) with the claim and indicates that the claim should be corrected and resubmitted. Once a claim has been approved by HCFA and paid or offset against prior payments to the LGA, the LGA may not revise and resubmit the claim, unless the State discovers an error in the claim and requests correction.

**Requests for Supplemental Funding.** On an as needed basis, the State is to notify the HCFA Regional Office of any requests for supplemental funding needed to pay allowable resolution period claims. Supplemental grant award requests are to be expeditiously processed by HCFA and the funds made available through the Payment Management System to ensure that there is no delay in the payment of allowable resolution period claims. The State determines if it is necessary at any time to revise its Form HCFA-37 (Medicaid Quarterly Budget Report) to reflect the amount of allowable resolution period claims being paid so as not to delay the availability of Federal funds.

**Reporting on Form HCFA-64.** The State, in consultation with HCFA, shall include the allowable resolution period expenditures on subsequent Form HCFA-64 (quarterly

expenditure report) submissions, taking into consideration, as appropriate, previous deferrals, disallowances and draw downs of Federal funds. In submitting the HCFA-64, the State should use a separate Form HCFA-64.10p for the resolution period claims for each fiscal year. To identify these claims, the State should enter "**RESOLUTION**" in the waiver identification box on the form.

## II. TRANSITION PERIOD

The following are the procedures that apply to claiming Targeted Case Management (TCM) services and Medi-Cal administrative activities during the January 1, 1995 through June 30, 1995 transition period.

1. The HCFA approved Master Allowable/Unallowable Listings for each program that were used during the resolution period are also applicable to the transition period.
2. The claim form for claiming Medi-Cal administrative activities during the transition period is attached (**see Attachment 2**). It is identical to the administrative claiming form used during the resolution period except it is designated for the transition period. This form must be used for claiming allowable Medi-Cal administrative activities during the transition period.
3. The claim form for claiming Medi-Cal TCM activities during the transition period is attached (**see Attachment 2**). This form is a modification of the administrative claim form to delete any claiming at the enhanced administrative matching rate for TCM activities and to reflect those activities which HCFA has approved for TCM claiming during the transition period. This form must be used for claiming allowable Medi-Cal TCM activities during the transition period.
4. When claiming for both TCM activities and Medi-Cal administrative activities during the transition period LGAs must report identical costs (Lines A-K) and revenues (Lines RA-RH) on both the TCM and administrative claim forms as illustrated on the attached claim forms.
5. On both the administrative claiming form and the TCM claiming form, Paid Time Off and General Administration are prorated among all activities (as was done during the resolution period) so that all activities bear their prorated share of Paid Time Off and General Administration.
6. All claiming units which formally elect to claim for TCM will be issued a letter containing their unique allowable TCM claiming percentages for the transition period and these percentages must be used in developing their TCM claim.
  - A. Those activities which have been approved as TCM activities during the transition period may only be claimed at the 50 percent Medicaid services matching rate for California. TCM activities can not be claimed at the enhanced administrative matching rate under any circumstances.

However, when the letter is issued containing the unique TCM claiming percentages for each claiming unit, the TCM percentages for skilled professional medical personnel (SPMP) and non-SPMP will be separately identified to facilitate development of the TCM claim since separate percentages were developed for the resolution period. Additionally, the

TCM claim form is constructed to only allow claiming for the TCM activities performed by SPMP at the 50 percent Medicaid services matching rate for California.

- B. Any activity which HCFA has approved as an allowable TCM activity during the transition period must only be claimed as a TCM activity during the transition period by any claiming unit which formally elects to claim for TCM.

In other words, an activity which was an allowable administrative activity during the resolution period that is now designated as an allowable TCM activity for the transition period, can only be claimed as a TCM activity by those claiming units which formally elect to claim for TCM. These claiming units can not choose to claim designated TCM activities as administrative activities during the transition period in order to get the enhanced administrative match for that activity or for any other reason.

7. All claiming units which formally elect to claim for TCM may also claim for those remaining allowable Medi-Cal administrative activities during the transition period. These claiming units will be issued a letter containing their Medi-Cal administrative claiming percentages for the transition period and these percentages must be used in developing their Medi-Cal administrative claim for the transition period.

For these claiming units, the allowable administrative activities during the transition period are those allowable administrative activities from the resolution period that are not now designated as allowable TCM activities.

8. During the transition period, all TCM activities must be discounted by the Medi-Cal percentage as a proxy for individual Medi-Cal claim submissions. The following two methods have been approved for the transition period to compute the Medi-Cal percentage:

(A) The claiming unit can use the same Medi-Cal percentage that was approved by HCFA for the first and second quarters of State fiscal year 1994/95 for the resolution period; or

(B) A Medi-Cal percentage based upon an actual "head count" methodology, approved by HCFA, of the total number of Medi-Cal recipients and the total number of all individuals served by the claiming unit calculated for at least one full month during the period April 1-June 30, 1995.

9. All claiming units which do not elect to claim for TCM can still claim for Medi-Cal administrative activities during the transition period. However, such claiming units will not be issued a new letter containing their administrative claiming percentages for the transition period. Those claiming units must use their same



activity percentage results and enhanced/nonenhanced designations as issued for the resolution period, and the Medi-Cal percentages (discount factor) used during the first and second quarters of State fiscal year 1994/95 to compute their Medi-Cal administrative claim for the transition period.

10. While the claiming unit is normally required to submit an individual claiming invoice for each quarter that is claimed, during the transition period the claiming unit may submit one invoice for the third and fourth quarters of State fiscal year 1994/95.

Therefore, if a claiming unit is claiming for both TCM and Medi-Cal administrative activities during the transition period, the claiming unit will submit one invoice for TCM and one invoice for Medi-Cal administrative activities, each containing identical cost/revenue data for the entire transition period.

Similarly, if a claiming unit is only claiming for Medi-Cal administrative activities during the transition period, the claiming unit will submit one invoice for Medi-Cal administrative activities containing all cost/revenue data for the entire transition period.

11. TCM services State plan amendments for Veteran's Services and Mental Health claiming units have not been submitted for the transition period. During the transition period these programs must only be claimed as Medi-Cal administration using the same activity result percentages for these claiming units that were used during the resolution period.
12. Drug and Alcohol Program claiming units may not submit claims for the resolution period or the transition period until; (1) the State submits a claiming proposal for claiming Drug and Alcohol Programs and such proposal is approved by HCFA, (2) the State and HCFA agree on an activity survey form for such programs and, (3) the results of such activity surveys are compiled and tabulated by the State and approved by HCFA.
13. The State recognizes that Federal financial participation (FFP) is not available for services provided free to the general public.
14. To ensure that payments for targeted case management services under the TCM SPAs do not duplicate payments made as part of a capitation rate, the State agrees to expressly exclude these targeted case management services from the range of services to be covered by Medi-Cal managed care plans and to require such plans to coordinate their activities with providers of TCM services under the SPAs.
15. Two separate actions have occurred which permit the State to claim FFP for TCM services provided by the counties during the transition period:

- 1) HCFA approved the six TCM State Plan Amendments (SPAs) effective January 1, 1995; and
  - 2) California enacted the appropriate State legislation to permit the counties to contract with the State to provide TCM services to Medi-Cal beneficiaries.
16. HCFA will not extend the transition period beyond June 30, 1995 for claiming TCM services or administrative activities.
17. HCFA, the State, and the local jurisdictions are bound by the approved percentages established through this transition process and they will not be subject to further audit, review, or modification by HCFA, the State, and the local jurisdictions.

### III. ADMINISTRATIVE CLAIMING PROCESS

#### CLAIMING MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA)

As part of the resolution of retroactive Medi-Cal Administrative Claiming (MAC), the Health Care Financing Administration (HCFA) and the State have discussed those residual administrative activities which are not included in Targeted Case Management (TCM) and for which the Local Governmental Agencies (LGAs) will be allowed to continue to claim Federal Financial Participation (FFP) after June 30, 1995. These administrative activities, known as "Medi-Cal administrative activities," (MAA) are described below. HCFA and the State agree that these Medi-Cal administrative activities are allowable administrative activities, the costs of which will be matched by HCFA, so long as the rules outlined below pertaining to Medi-Cal administrative claiming are adhered to.

Each LGA that intends to claim for the costs of MAA must submit a comprehensive MAA claiming plan to the State. Such a claiming plan shall describe in detail all of the following:

- a. The categories of Medi-Cal administrative activities for which the LGA intends to claim, selected from the list below;
- b. The claiming units for which claims will be submitted, the nature of their work, their location, and the types of employees involved;
- c. The supporting documentation the claiming unit will maintain to support its claim; and
- d. How the costs related to these Medi-Cal administrative activities will be developed and documented.

For certain categories of MAA, additional documentation must be submitted with the claiming plan, as explained below.

Once submitted to the State, each LGA's claiming plan will be reviewed in a timely manner by the State and, after approval, submitted to HCFA. HCFA agrees to review and comment on these detailed claiming plans, and to approve acceptable plans, in a timely manner. Once approved by the State and HCFA, these MAA claiming plans will become part of annual agreements between the LGAs and the State and will form the basis for Medi-Cal administrative claiming. Claims submitted to the State without an approved claiming plan or which do not agree with the approved claiming plan will be rejected. A claiming plan will remain in effect from year to year until amended. A LGA may submit amendments to its claiming plan at any time. A claiming plan must be amended each time the scope of MAA are significantly changed or a new type of activity is undertaken. For example, a LGA outreach claiming plan must be amended when a new outreach campaign or program is instituted. Amendments will be subject to the approval process described above.

NOTE: In Local Educational Agencies (LEAs) TCM case managers will not be permitted to claim for MAA, as well as TCM.

Based upon the principles for supporting salaries and wages embodied in OMB Circular A-87, as amended May 17, 1995, allocating charges for the supervisors, clerical, and support staffs of sampled TCM case managers and employees directly engaged in MAA may be claimed based upon the results of the time studies of the sampled employees.

HCFA reserves the right to audit MAA claims in accordance with established procedures and protocols.

The following MAA are allowable as Medi-Cal administration:

1. Medi-Cal Outreach: This activity is NON-ENHANCED (matched at the 50 percent rate). The only allowable Medi-Cal outreach for purposes of Medi-Cal administrative claiming is to groups or individuals targeted to two goals:
  - a. Bringing potential eligibles into the Medi-Cal system for the purpose of determining Medi-Cal eligibility; and
  - b. Bringing Medi-Cal eligible people into Medi-Cal services.

Outreach may consist of discrete campaigns or may be an ongoing activity, such as: sending teams of employees into the community to contact homeless alcoholics or drug abusers; establishing a telephone or walk-in service for referring persons to Medi-Cal services or eligibility offices; operating a drop-in community center for underserved populations, such as minority teenagers, where Medi-Cal eligibility and service information is disseminated. LEAs may only conduct outreach to the populations served by their school districts, i.e., students and their parents or guardians. The State will document to HCFA's satisfaction that the public health outreach conducted by LGAs does not duplicate the requirements on Medi-Cal managed care providers to pursue the enrollment of Medi-Cal eligibles in their service areas.

**NOT ALLOWABLE:** Some activities are not considered Medi-Cal outreach under any circumstances, as follows:

- General preventive health education programs or campaigns addressed to lifestyle changes in the general population (e.g., SANE, DARE, dental prevention, antismoking, alcohol reduction, etc.) are not allowable MAA.
- Outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medi-Cal are not allowable.

**ALLOWABLE:** Allowable outreach activities may be discounted by the Medi-Cal percentage or not discounted as follows:

**NOT DISCOUNTED:** Outreach campaigns directed to the entire population to encourage potential Medi-Cal eligibles to apply for Medi-Cal are allowable, and the costs do not have to be discounted by the Medi-Cal percentage. These campaigns are essentially Medi-Cal only eligibility outreach campaigns. Outreach campaigns directed toward bringing Medi-Cal eligibles into Medi-Cal covered services are allowable and the costs also do not have to be discounted by the Medi-Cal percentage. These campaigns are service campaigns, targeted on specific Medi-Cal services, such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (known in California as Child Health and Disability Prevention Program (CHDP)).

A health education program or campaign may be allowable as a Medi-Cal administrative cost if it is targeted specifically to Medi-Cal services and for Medi-Cal eligible individuals, such as an educational campaign on immunization addressed to parents of CHDP children. If the entire campaign is focused on Medi-Cal, the costs need not be discounted.

**DISCOUNTED:** Outreach campaigns directed toward bringing specific high risk populations (including both Medi-Cal and non-Medi-Cal persons), for example, low income pregnant women or substance abusers, into health care services, are only allowable to the extent they bring Medi-Cal eligibles into Medi-Cal services. The costs of these activities are claimable as Medi-Cal administration, but discounted by the Medi-Cal percentage.

If a specific Medi-Cal health education program is included as part of a broader general health education program, the Medi-Cal portion may be allowable if the cost of the general health education program is discounted according to the Medi-Cal percentage.

Telephone, walk-in, or drop-in services for referring persons to Medi-Cal services, sometimes called "Information and Referral" are also allowable and discounted by the Medi-Cal percentage.

County-wide averages or other reasonable methods approved by HCFA for calculating the Medi-Cal percentage discount may be utilized.

The claiming plan must clearly state the nature of outreach programs or campaigns for which the provider will be claiming federal reimbursement. The claiming plan must describe the purpose of the outreach activity, the target population, the number of staff conducting the activity (by classification), and the estimated length (time) of the activity. The LGA must explain the method for calculating the Medi-Cal discount. In addition, the LGA must attach copies of announcements or fliers describing the outreach campaigns and a sample of materials which have been developed for the campaigns.

The LGA may contract with non-governmental agencies or programs to conduct outreach activities. In addition, TCM case managers, except in LEAs, may conduct outreach activities, as well as TCM, provided there is an accurate accounting and reporting of the time spent on each.

2. Facilitating Medi-Cal Application (Eligibility Intake): This activity is NON-ENHANCED (matched at the 50 percent rate.) This activity includes the following tasks separately or in combination: explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants; assisting an applicant to fill out a Medi-Cal eligibility application; gathering information related to the application and eligibility determination or redetermination from a client, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medi-Cal application to the county welfare department; providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination. This activity does not include the eligibility determination itself. These costs do not have to be discounted by the Medi-Cal percentage.

The LGA may contract with non-governmental agencies or programs to conduct eligibility intake activities. TCM case managers, except in LEAs, may conduct eligibility intake, so long as there is an accurate accounting and reporting of the time spent on each.

3. Medi-Cal Non-Emergency Transportation: This activity is NON-ENHANCED (matched at the 50 percent rate). The actual costs of arranging and providing non-emergency transportation, and accompaniment, when medically necessary, by an attendant, not a TCM case manager, of Medi-Cal eligibles to Medi-Cal services are allowable as a Medi-Cal administrative cost to the extent that such costs are actually borne by the county in accordance with 42 Code of Federal Regulations, Section 440.170. Examples of allowable non-emergency transportation costs include: taxi vouchers, bus tokens, mileage, etc. The cost of providing non-emergency transportation for which no actual cost is borne by the State or local jurisdiction is not an allowable Medi-Cal administrative cost.

**SEPARATE TRANSPORTATION UNIT OR SERVICE:** In situations where a local jurisdiction operates a separate transportation unit or contracts for the provision of transportation services, the costs of the unit or the contractor of actually providing the Medi-Cal non-emergency transportation services for Medi-Cal eligibles to Medi-Cal services is an allowable Medi-Cal administrative cost. Costs may be calculated on a per mile or per trip basis for each Medi-Cal client transported or by any other reasonable method.

**TRANSPORTATION COSTS AND TCM:** The costs of arranging for transportation of Medi-Cal eligibles to Medi-Cal services is part of the TCM rate. Therefore, the costs incurred by TCM case managers in arranging transportation for Medi-Cal eligibles to Medi-Cal services are not claimable as Medi-Cal administration. The TCM rate includes the travel costs incurred by the TCM

case manager in providing the TCM services. A TCM case manager may transport or accompany a Medi-Cal eligible to a Medi-Cal service appointment only if the case manager is performing case management functions while actually accompanying the client. In such situations, the costs of the accompanying and transportation will be in the TCM rate and should not be claimed separately as an administrative activity.

The detailed claiming plan should explain what staff, units, or contractors of the LGA are responsible for providing transportation of Medi-Cal eligibles to Medi-Cal services and how the costs of such transportation are being calculated and claimed.

4. Training: This activity is matched at the ENHANCED rate (75 percent) only when training is provided for or by Skilled Professional Medical Personnel (SPMP) and qualifies under the criteria below. The only SPMP administrative training activities that are allowable at the 75 percent Federal administrative matching rate are those SPMP administrative training activities that directly relate to the SPMP's performance of his or her specifically allowable SPMP administrative activities. Medical or health-related training that is provided to or conducted by an SPMP that is unrelated to that SPMP's performance of his or her administrative activities is not allowable at 75 percent as Medi-Cal administration.

The only training activities matchable under MAA at the enhanced rate are those related to program planning and policy development, and only when the training is provided by or for a SPMP in accordance with the above criteria.

Training by or for SPMPs and non-SPMPs is matched at the NON-ENHANCED rate (50 percent) when it directly relates to non-enhanced Medi-Cal administrative activities (such as, outreach, eligibility intake, and contracting).

5. Contracting for Medi-Cal Services: This activity is NON-ENHANCED (claimed at the 50 percent rate). This activity involves entering into contracts with community based organizations (CBO) or other provider agencies to provide Medi-Cal services, other than TCM. The costs of TCM subcontractor administration should be included in the TCM rate.

Contracting for Medi-Cal services is claimable as an administrative activity when the contract administration meets all of the following criteria:

- a. The contract administration is performed by an identifiable unit of one or more employees, whose tasks officially involve contract administration, according to position descriptions.
- b. The contract administration involves contractors which provide Medi-Cal services. The LGA's costs of managing a contract for allowable administrative activities, such as outreach, should be claimed under that

activity category, and not separately as contract administration. The costs of contracting for TCM services with non-LGA providers should be claimed as part of the TCM rate. These costs can not be separately claimed as MAA.

- c. TCM case managers and LGA subcontractors, except for school district staff, cannot perform contract management. It must be a LGA function. Schools may contract for Medi-Cal services in connection with the Local Educational Agency (LEA) billing option.
- d. The administrative costs of contracting by LGAs as service providers under managed care arrangements may not be claimed administratively and are considered to be in the capitation payment to the LGA.
- e. The contract administration must be directed to one or more of the following goals:
  - (1) Identifying, recruiting, and contracting with community agencies as Medi-Cal service contract providers;
  - (2) Providing technical assistance to Medi-Cal subcontractors regarding County, State and Federal regulations;
  - (3) Monitoring provider agency capacity and availability; and
  - (4) Ensuring compliance with the terms of the contract.

The contracts being administered may involve Medi-Cal patients only or may be general medical service contracts involving Medi-Cal and other indigent, non-Medi-Cal patients. When the contract involves a Medi-Cal and non-Medi-Cal population, the costs of contract administration will be discounted by the Medi-Cal percentage. In addition, a LGA/LEA may use a reasonable basis for apportioning the time of employees who administer contracts involving Medi-Cal and non-Medi-Cal activities and services, including the allocation of time based on the percentage of costs under the contract related to Medi-Cal.

The LGA must submit a detailed claiming plan which identifies the unit and employees who perform contract administration, the types of contracts administered, the populations being served, the Medi-Cal percentage served by the contractors or a methodology for determining that percentage, and the method for allocating time spent by employees between Medi-Cal and non-Medi-Cal contract functions. Also, the position descriptions/duty statements of the employees being claimed must be attached to the claiming plan, as well as copies of a sample of contracts being administered. If employees perform contract administration 100 percent of their time, the costs of this activity will not be time studied but may be claimed on the direct charge portion of the claim.



6. Program Planning and Policy Development: This activity may be ENHANCED (at 75 percent) if performed by a SPMP, or NON-ENHANCED (at 50 percent) if performed by a non-SPMP.

NOT ALLOWABLE: If staff performing this function are employed full time by LGA service providers, such as clinics, the full costs of the employee's salary are assumed to be included in the billable service rate and separate administrative claiming is not allowed.

The costs of employees who work part time performing program planning and policy development should be included in the general administration category which will be allocated on the claim form.

Program planning and policy development activities are not allowable administrative activities when performed by TCM case managers or LGA subcontractors, with the exception of LEA staff.

ALLOWABLE: This activity is directly claimable as Medi-Cal administration only when program planning and policy development is performed full time by a unit of one or more LGA/LEA employees whose tasks officially involve program planning and policy development, according to their position descriptions/duty statements. The costs of planning and development activities will be allocated according to the Medi-Cal percentages being served by the programs being coordinated, if the programs serve both Medi-Cal and non-Medi-Cal clients. Because employees perform this activity full time, their costs may be claimed on the direct charge portion of the claim.

In counties with county wide managed care arrangements, program planning and policy development activities are claimable as Medi-Cal administration only for those services which are excluded from the managed care contracts.

Under the conditions specified above, the following tasks are allowable as administrative activities under program planning and policy development:

- a. Developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps; includes analyzing Medi-Cal data related to a specific program or specific group;
- b. Interagency coordination to improve delivery of Medi-Cal services;
- c. Developing resource directories of Medi-Cal services/providers.

The claiming plan must identify the units or employees who are being claimed, whether or not they are SPMP; the specific tasks they perform in relation to program planning and policy development; the health programs involved in the

planning and development; the location of the activities; how the Medi-Cal percentage will be developed; and present documentation that the costs of the employees being claimed are not included in LGA/LEA general administrative overhead. The time of employees engaged part-time in program planning and policy development should be claimed under general administration.

7. General administration: This includes activities that are eligible for cost distribution on an approved cost allocation basis. These costs are to be distributed proportionately to all of the activities performed:
  - a. Attend or conduct general, non-medical staff meetings;
  - b. Develop and monitor program budgets;
  - c. Provide instructional leadership, site management, supervise staff, or participate in employee performance reviews;
  - d. Review departmental or unit procedures and rules;
  - e. Present, or participate in, in-service orientations and programs;
  - f. Participate in health promotion activities for county employees; and
  - g. Earn compensatory time off.
8. Paid time off: This function is to be used by all staff involved in MAA activities to record usage of paid leave, including vacation, sick leave, holiday time and any other employee time off that is paid. This does not include lunch or meal breaks, off payroll time, or compensatory time off (CTO). This is also allocated on an approved cost allocation basis.
9. MAA/TCM Coordination and Claims Administration: LGA employees whose position description/duty statement includes the administration of the TCM and the ACP on a LGA-wide basis may claim directly for the costs of these activities on the claiming form as a direct charge. In addition, costs incurred in preparation and submission of MAA claims at any level, including staff time, supplies, and computer time, may be direct charged. If the MAA/TCM Coordinator and/or claims administration staff are performing this function part-time, along with other duties, the MAA/TCM Coordinator and/or claims administration staff must certify the percentage of time spent on each of the activities. The percentage certified for the MAA/TCM Coordinator/claims administration staff activities will be used as the basis for Federal claiming.

The MAA/TCM Coordinator and claims administration staff may claim the costs of the following activities, as well as any other reasonable activities directly related to the administration of TCM services and MAA. All of these activities must be detailed in the administrative claiming plan. The claiming plan should

identify the staff engaged in MAA/TCM coordination and claims administration, their location in the organizational structure, and include copies of their position descriptions/duty statements. The claiming plan must also describe the documentation, including time studies, used to support the percentage of time certified for MAA/TCM coordination/claims administration activities.

NOTE: The claiming plan description of MAA/TCM coordination and claims administration activities may be submitted separately for approval prior to submission of the complete comprehensive MAA claiming plan for the FIRST YEAR OF MAA claiming (beginning July 1, 1995) in order to allow Federal funds to flow to LGAs for administrative support as soon as possible.

- a. Drafting, revising, and submitting MAA claiming plans.
- b. Serving as liaison with claiming programs within the LGA and with the State and Federal governments on TCM and MAA.
- c. Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting TCM and MAA claims on LGA-wide basis to the State.
- d. Attending training sessions, meetings, and conferences involving TCM and/or MAA.
- e. Training LGA program and subcontractor staff on State, Federal, and local requirements for TCM and MAA claiming.
- f. Ensuring that TCM or MAA claims do not duplicate Medi-Cal claims for the same activities from other providers.

NOTE: The costs of the TCM/MAA Coordinators' time and claims administration staff time must not also be included in the TCM rate or in MAA claiming, since the time is to be direct charged. Charges for supervisors, clericals, and support staff for these employees may be allocated based upon the percentage of certified time of the TCM/MAA Coordinator and claims administration staff. The costs of TCM claiming activity at the TCM provider level are to be included in the TCM rate.

10. Mental Health Administrative Activities—The ACP for mental health claiming units in LGAs will be governed by the agreement between HCFA and the State contained in correspondence of June 12, 1995, July 19, 1995, and July 26, 1995 (**see Attachment 6**) with the exception below.

Mental health claiming units must submit a claiming plan detailing which functions will be claimed and how activities and personnel claimed at the enhanced SPMP matching rate of 75 percent meet the requirements of

42 CFR 432.50. This claiming plan will be reviewed by the State Department of Mental Health before being reviewed by the State Department of Health Services and submitted to HCFA. It will not be part of the LGA comprehensive claiming plan. However, in all other respects, it must meet the requirements outlined in this section for MAA claiming plans.

**IV. TCM RATE CONTENTS**

For purposes of clarifying the claiming of various costs, the State and HCFA agree that the costs of performing the following activities are included in the TCM service rate:

- a. Staffing cases through team meetings and interagency coordination time;
- b. Case manager travel time and costs when performing TCM duties;
- c. Case manager time to arrange client transportation and appointments;
- d. Preparing/documenting case records;
- e. Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from a vendor to enable communication between the client and case manager.

NOTE: When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

- f. Supervision of case managers;
- g. Case manager non-SPMP training;
- h. TCM subcontract administration when performed by an identifiable unit or one or more employees not otherwise claimed or funded through established rates or other programs, to:
  - (1) Identify and recruit community agencies as TCM contract providers;
  - (2) Develop and negotiate TCM provider subcontractor performance to ensure appropriate delivery of TCM services to eligible beneficiaries;
  - (3) Monitor TCM provider subcontracts to ensure compliance with Medi-Cal regulations;
  - (4) Provide technical assistance to TCM subcontractors regarding county, Federal, and State regulations;

- i. TCM data systems and claiming coordination, including:
  - (1) Input of Medi-Cal data from the Encounter Log into the data collection system;
  - (2) Reconciliation of TCM Medi-Cal encounter claims reported as rejected by the State;
  - (3) Maintaining and analyzing Medi-Cal TCM management information systems; and
  - (4) Preparing, reviewing, and revising TCM claims.
- j. TCM quality assurance/performance monitoring, including:
  - (1) TCM case documentation compliance;
  - (2) TCM "free care" and TPL compliance;
  - (3) Preventing duplication of services and ensuring continuity of care when a Medi-Cal recipient receives TCM services from two or more programs; and
  - (4) Monitoring Medi-Cal TCM provider agency capacity and availability.

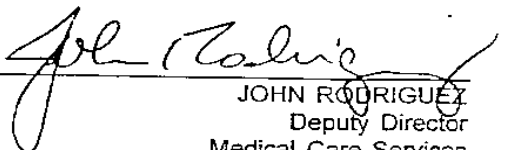
NOTE: Activities "h", "i" and "j" cannot be performed by a case manager or other service provider.

- k. TCM program planning and policy development, including:
  - (1) Planning to increase TCM system capacity and close gaps;
  - (2) Interagency coordination to improve TCM service delivery;
  - (3) Developing policies and protocols for TCM; and
  - (4) Developing TCM resource directories.
- l. County Overhead, which includes:
  - (1) Operating expenses and equipment;

- (2) Accounting;
- (3) Budgets;
- (4) Personnel;
- (5) Business Services;
- (6) Clerical Support;
- (7) Management; and
- (8) County Indirect Costs from Indirect Costs  
Rate Plan (ICRP)

For the STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES:

Dated: 11/2/95

  
JOHN RODRIGUEZ  
Deputy Director  
Medical Care Services

Dated: 11-2-95

  
ELISABETH C. BRANDT  
Deputy Director and Chief Counsel

Dated: 11/2/95

  
ROBERTA M. WARD  
Staff Attorney

For the HEALTH CARE FINANCING ADMINISTRATION:


Dated: 11/21/95

  
BRUCE VLADECK  
Administrator

Dated: 11/28/95


  
ELIZABETH ABBOTT  
Acting Regional Administrator

Dated: 11/3/95

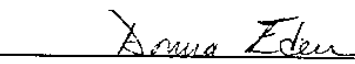
  
BILL LASOWSKI  
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